CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00115/6

TITLE: Arkansas Medicaid Section 1115 Health Care Reform Demonstration (ARKids B)

AWARDEE: Arkansas Department of Human Services

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I. PREFACE

The following are Special Terms and Conditions for the award of the Arkansas Medicaid Section 1115 Health Care Reform Demonstration (ARKids B) waiver request submitted on May 13, 1997. The Special Terms and Conditions have been arranged into three broad subject areas: General Conditions for Approval, Legislation, and Program Design/Operational Plan.

In addition, specific requirements are attached entitled: General Financial Requirements (Attachment A); General Program Requirements (Attachment B); General Reporting Requirements (Attachment C); Monitoring Budget Neutrality (Attachment D); Contractor's Access Standards (Attachment E); and Operational Protocol (Attachment F).

The State agrees that it will comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. As part of the review of the operational protocol that the State is required to submit, CMS will examine the State's proposed operational procedures to ensure their consistency with the requirements set forth in the above Federal statutes.

Letters, documents, reports, or other material that is submitted for review or approval will be sent to the Arkansas Demonstration Project Officer and the Arkansas State Representative in the Dallas Regional Office.

II. GENERAL CONDITIONS

A. All Special Terms and Conditions prefaced with an asterisk (*) contain requirements that must be approved by the Centers for Medicare & Medicaid Services (CMS) prior to program implementation. (For purposes of this section, implementation is defined as the first date on which Medicaid beneficiaries are restricted (locked-in) to a single Primary Care Physician (PCP) for 6 months.) No Federal Financial Participation (FFP) will be provided for section 1115 program implementation until CMS has approved these requirements. FFP will be available for project development and implementation, compliance with Special Terms and Conditions, the readiness review, etc. Unless otherwise specified, where the State is required to obtain CMS approval of a submission, CMS will make every effort to respond to the submission in writing within 45 days of receipt of the submission. CMS and the State will make every effort to ensure that each submission is approved within 60 days from the date of CMS's receipt of the original submission.

B.* The State will prepare one protocol document that represents and provides a single source for the policy and operating procedures applicable to this demonstration which have been agreed to by the State and CMS during the course of the waiver negotiation and approval process. The protocol must be submitted to CMS no later than 30 days prior to program implementation. CMS will respond within 30 days of receipt of the protocol regarding any issues or areas it believes require clarification. During the demonstration, subsequent changes to the protocol that are the result of major changes in policy or operating procedures should be submitted no later than 30 days prior to the date of implementation of the change(s) for approval by CMS. The Special Terms and Conditions and Attachments include requirements that should be included in the protocol. Attachment F is an outline of areas that should be included in the protocol.

C. The State will submit a phase-out plan of the demonstration to CMS 6 months prior to initiating normal phase-out activities and, if desired by the State, an extension plan on a timely basis to prevent disenrollment of beneficiaries if the waiver is extended by CMS. Nothing herein will be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS review and approval.

D. CMS may suspend or terminate any project, in whole or in part, at any time before the date of expiration whenever it determines that the awardee has materially failed to comply with the terms of the project. CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights under 42 CFR 430, Grants to States for Medical Assistance Programs, to challenge CMS's finding that the State materially failed to comply. CMS reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, CMS will be liable only for normal close-out costs.

E. The State will comply with:

1. General Financial Requirements (Attachment A)
2. General Program Requirements (Attachment B)
3. General Reporting Requirements (Attachment C)
4. Monitoring Budget Neutrality (Attachment D)
5. Contractor's Access Standards (Attachment E)
6. Operational Protocol (Attachment F)

III. LEGISLATION

A. All requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are part, will apply to the Arkansas Demonstration. To the extent the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the Arkansas Demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. CMS will have two years after the waiver award date to notify the State that it intends to take action. The growth rates for the budget neutrality baseline, as described in Attachment D, are not subject to this Special Term and Condition. If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the Arkansas Demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the Arkansas Demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

B. The State will, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that take effect after the waiver award date. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the waiver, CMS will incorporate such changes into a modified budget limit for the Arkansas Demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program components that are or are not affected by the Arkansas Demonstration (e.g., laws affecting sources of Medicaid funding), the State will submit its methodology to CMS for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in Arkansas, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-waiver States.

C. The State may submit to CMS a request for an amendment to the Arkansas Demonstration program to request exemption from changes in law taking effect after the waiver award date. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under a modified Arkansas Demonstration program do not exceed projected expenditures in the absence of the Arkansas Demonstration (assuming full compliance with the change in law).

IV. PROGRAM DESIGN/ OPERATIONAL PLAN

A. Beneficiary Education and Enrollment

1. At the time of implementation, and throughout the demonstration, the State will continue to maintain a sufficient number of beneficiary hotlines (with interpretation services) to accommodate concerns and questions of beneficiaries during standard physician operating hours. The State will monitor beneficiary hotlines in order to ensure that acceptable standards are being maintained. Monitoring measures should include components such as a) the number of overflow calls, i.e. calls not answered due to a busy signal; b) the average duration of each call; c) the total number of calls handled per day/week/month; d) the average number of calls per day; e) the average hours of use per day; f) the busiest area code/county; and g) the busiest day of the week by number of calls.

2. ARKids B applicants will receive all the educational materials provided to other ConnectCare participants. In addition, an informational pamphlet that describes the ARKids B program, including the reduced benefit package and the copayment provisions, must be provided. A list of PCPs that are appropriate to the applicant's location will be available by calling the Medicaid toll-free hotline. The following will also be provided to ARKids B applicants: information concerning the process for selecting a PCP, including a statement that the applicant must choose a PCP at the time of application or the application will be denied; information regarding an individual's right to change PCPs and the frequency with which a change may be made; information concerning the availability of beneficiary hotlines and the grievance and appeals process; and information regarding the enrollee's right to self-refer for specific service (family planning visits, etc.).

3. Enrollees will be entitled to change their PCP selection every 6 months. Enrollees will be entitled to change their PCP selection at any time, without limitation, for good cause. As part of the enrollment materials, enrollees will be provided with information concerning their disenrollment rights.

B. Coordination of Services

Linkage Agreements - As part of the protocol, the State must describe how PCPs are expected to develop linkage agreements and coordinate care for their beneficiaries with such entities as behavioral health providers, public health agencies, school-based health clinics, and family planning clinics. The description will include the process for exchanging patient-specific information while protecting the confidentiality of the patient.

C. Provider Netvork

The Primary Care Physician Program known as "ConnectCare", which is operated under a section 1915(b) waiver, will be the provider network for the ARKids B program. The provider network will be large enough to ensure adequate access to PCPs and specialists. The maximum patient/PCP provider ratio will not exceed 1000:1, including patients other than ARKids B enrollees. The State, subject to CMS approval, may approve exceptions to this standard in specified situations.

D. Access Standards

1.* The State must demonstrate that ARKids B beneficiaries have an adequate number of accessible facilities, service sites, and allied professional services. If CMS decides to run a computer mapping program, the State will make available (electronically) addressees of demonstration eligibles and providers. (Specific access standards are listed in Attachment E.)

2. Prior to implementation, and annually thereafter, the State must provide CMS with an updated listing of all participating providers (primary and specialty).

3.* The State will notify CMS on a timely basis of any significant changes to any provider network that materially, as defined in the protocol, affect access and quality of care. The State will define within its protocol contingency plans for assuring continued access to care for enrollees.

4. The State must monitor providers to ensure that they are conforming with the standards outlined in the Americans with Disabilities Act for purposes of communicating with, and providing accessible services for the hearing and vision impaired, and physically disabled beneficiaries.

E. Quality Assurance

1.* Monitoring Plan for PCPs - As part of the protocol, the State will provide its overall quality assurance monitoring plan, including the required access and quality standards that providers must meet to provide services to beneficiaries. The State will submit to CMS copies of all quality assessment reviews. The State will establish a quality improvement process for bringing PCPs that are below the State's performance benchmarks up to an acceptable level. The State will define the benchmarks in the operational protocol.

2. Quality Improvement - The State, in collaboration with PCPs and other appropriate parties, will develop and submit to CMS a detailed plan for using claims data to pursue health care quality improvement within 90 days of implementation of the demonstration. At a minimum, the plan will include: how the baseline for comparison will be developed; which HEDIS indicators of quality

will be used to determine if the desired outcomes are achieved; where the data will be stored; and how data will be validated and how monitoring will occur, and what corrective actions will be taken as specified in the contract. At a minimum, the State's plan for using claims data to pursue health care quality improvement must describe how the data will be used to study the following priority areas:

childhood immunizations;
birth outcomes;
pediatric asthma;
and two additional clinical conditions to be determined by the State based upon the population(s) served.

3. Beneficiary Survey - Within 15 months of implementation, the State will contract for a beneficiary survey. The survey will be generally described in the operational protocol and provided to CMS for review a minimum of 60 days prior to use. At a minimum, the survey will include such measures as the beneficiary's satisfaction with program administration and care provided and include measures of use of emergency rooms; waiting times for appointments (primary care and specialists); and access to special providers. Results of the survey must be provided to CMS by the 18th month of project implementation. Thereafter, the State will conduct annual beneficiary surveys. Such surveys will be designed to produce statistically valid results.

4. Grievance and Appeal Process - The State will monitor the grievance and appeal process to assure that beneficiaries' concerns are resolved timely, that confidentiality is protected, and that coordination between the hotline representative and the State is occurring in an efficient and effective manner. At a minimum, as part of this monitoring effort, the State will collect and review quarterly reports on grievances received by each hotline representative that describe the resolution of each formal grievance. Quarterly reports must also include an analysis of logs of informal complaints (which may be verbally reported to customer service personnel) as well as descriptions of how formal (written) grievances and appeals were handled.

F. Copayments

1. For ARKids B enrollees, copayments will apply, as appropriate, for all services with the exception of immunizations, preventive health screenings, family planning and prenatal care. Copayments range from $5.00 per prescription to 20% of the first day's hospital per diem. There is a $10.00 copayment for most outpatient services.

2. Copayments will be collected by providers, and will be deducted from the total reimbursement amount paid to them. Current State plan provisions regarding participation by providers will apply, as described in 42 CFR 447.15.

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS

1. The State will provide quarterly expenditure reports using the Form HCFA-64 to report total expenditures for services provided under the Medicaid program, including those provided through the ARKids B Demonstration under section 1115 authority. CMS will provide Federal Financial Participation (FFP) only for allowable ARKids B Demonstration expenditures that do not exceed the pre-defined limits as specified in Attachment D (Monitoring Budget Neutrality for the ARKids B Demonstration).

2. a. In order to track expenditures under this demonstration, the State will report ARKids B Demonstration expenditures through the Medicaid Budget and Expenditure System (MBES), as part of the routine HCFA-64 reporting process. Expenditures subject to the budget neutrality cap will be reported on separate Forms HCFA-64.9s, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered). The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.c.

   b. For each demonstration year, a separate Form HCFA-64.9 will be submitted reporting expenditures subject to the budget neutrality cap. This form will contain the combined total of all expenditures for ARKids B Demonstration enrollees.

   c. For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include all Medicaid expenditures on behalf of ARKids B Demonstration enrollees, which will include FFS expenditures for all Medicaid services that are administered by the Arkansas Department of Human Services, Division of Medical Services.

   d. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. During the period following the conclusion or termination of the demonstration, the State must continue to separately identify expenditures subject to the budget neutrality cap, using the procedures addressed above.

   e. The procedures related to this reporting process will be included in the Operational Protocol to be submitted by the State to CMS under Attachment F.

3. a. For the purpose of calculating the budget neutrality expenditure cap described in Attachment D, the State will provide to CMS on a quarterly basis the actual number of eligible member/months (as defined in 3.b.). These will include only member/months for ARKids B Demonstration enrollees. This information should be provided to CMS 30 days after the end of

each quarter as part of the HCFA-64 submission under the narrative section of the MBES or as a stand-alone report. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY will be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) Procedures for reporting eligible member/months will be defined in the Operational Protocol.

b. The term, "eligible member/months" will refer to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member/months to the total. Two individuals who are eligible for two months, each contribute two eligible member months to the total, for a total of four eligible member/months.

4. The standard Medicaid funding process will be used during the demonstration. Arkansas must estimate matchable Medicaid expenditures on the quarterly Form HCFA-37. The State must provide supplemental schedules that provide updated estimates of expenditures for the waiver population. CMS will make Federal funds available each quarter based upon the State's estimates, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form HCFA-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form HCFA-64 with Federal funding previously made available to the State for that quarter, and include the reconciling adjustment in a separate grant award to the State.

5. CMS will provide Federal Financial Participation (FFP) at the applicable Federal matching rate for the following, subject to the limits described in Attachment D:

   a. Administrative costs, including those associated with the administration of the ARKids B Demonstration, which will not be included in the cost per eligible per month used for the budget neutrality determination;

   b. Net expenditures of the Medicaid program and prior period adjustments which are paid in accordance with the approved State Plan (including disproportionate share hospital payments); and

   c. Net medical assistance expenditures made under Section 1115 waiver authority, including those made in conjunction with the ARKids B Demonstration.

6. The State will certify State/local monies used as matching funds for the Arkansas Demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

ATTACHMENT B

GENERAL PROGRAM REQUIREMENTS

1. CMS may contract with an independent contractor to evaluate the demonstration. The State agrees to cooperate with the evaluator (at no cost), by responding in a timely manner to requests for interviews, providing access to records, and sharing data, including the claims and eligibility files. The State has the right to review reports and the right to comment on reports prepared by the evaluator.

2. CMS may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights under 42 CFR 430, Grants to States for Medical Assistance Programs, to challenge CMS's finding that the State materially failed to comply. CMS reserves the right to withhold waivers pending or to withdraw waivers at any time if it determines that granting or continuing the waivers would no longer be in the public interest. If the waiver is withdrawn, CMS will be liable for only normal close-out costs.

3. The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for the suspension or termination, together with the effective date. If the waiver is withdrawn, CMS will be liable for only normal close-out costs.

ATTACHMENT C

GENERAL REPORTING REQUIREMENTS

1. By April 1 of each year, the State will submit a separate Form HCFA-416 for ARKids B eligibles (EPSDT program reports) for the previous Federal fiscal year. These reports will follow the format specified in section 2700.4 of the State Medicaid Manual, with data for each applicable line arrayed by age group. All data reported will be supported by documentation consistent with the general requirements of these terms and conditions.

2. The State will continue its participation in the Medicaid Statistical Information System (MSIS) through the regular quarterly submission of MSIS files to CMS. Expanded eligibility groups in the demonstration also need to be reported. These groups will be reported in Maintenance Assistance Status 3 (Poverty Related), with the appropriate Basis Of Eligibility, as detailed in the MSIS Tape Specifications and Data Dictionary. Additionally, the State will submit a revised eligibility crosswalk for State-specific eligibility codes that clearly identifies the codes that refer to individuals eligible as a result of the expansion.

3. Through the first 6 months after implementation, CMS and the State will hold monthly calls to discuss progress. Further, the State will submit quarterly progress reports that are due 60 days after the end of each quarter. The reports should include, as appropriate, a discussion of events occurring during the quarter that affect health care delivery, including enrollment and outreach activities; access; quality of care; complaints and appeals to the State; beneficiary telephone hot line performance; the referral system; out-of-network services; the benefit package; mental health coordination under the demonstration; and other operational and policy issues. The report should also include proposals for addressing any problems identified in each report.

4. The State will submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after the end of its operational year. Within 30 days of receipt of comments from CMS, a final annual report will be submitted.

5. At the end of the demonstration, a draft final report should be submitted to CMS for comments. CMS's comments must be taken into consideration by the State for incorporation into the final report. The State should use CMS's Office of Research and Demonstrations' *Author's Guidelines: Grants and Contracts Final Reports* (copy attached) in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.

6. The State will submit a phase-out plan for the demonstration to CMS 6 months prior to initiating normal phase-out activities or, if desired by the State, an extension plan on a timely basis to prevent disenrollment of members if the waiver is extended by CMS. Nothing herein will be construed as preventing the State from submitting a phase-out plan

with an implementation deadline shorter than 6 months when such action is necessitated by emergency circumstances. The phase-out plan is subject to CMS review and approval.

7. The State will submit a continuation application 270 days after the effective date of the award and yearly thereafter.

ATTACHMENT D

MONITORING BUDGET NEUTRALITY FOR THE ARKIDS B DEMONSTRATION

1. Arkansas will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. This limit will apply to expenditures made on behalf of children enrolled in ARKids B who are made eligible for Federal financial participation (FFP) through the demonstration. The calculation of the limit is described in item 3 below.

2. a. For the purpose of calculating the budget neutrality limit, the State will provide to CMS on an quarterly basis the actual number of eligible member/months for ARKids B enrollees. This information should be provided to CMS 30 days after the end of each quarter as part of the HCFA-64 submission under the narrative section of the MBES or as a stand-alone report.

   b. The State will report eligible member/months for ARKids B enrollees for each quarter beginning September 1, 1997 until the end of the demonstration.

3. The following describes the method for calculating the budget neutrality limit:

   a. For each demonstration year (DY) (October through September), a separate annual limit is calculated.

   b. The annual limit will be calculated as the product of the number of eligible member/months reported by the State for ARKids B enrollees times the appropriate estimated per member/per month (PM/PM) cost from the table in item 3.d. below.

   c. The budget neutrality limit is the sum of the annual limits for the 5 years of the demonstration. The Federal share of the budget neutrality limit represents the maximum amount of FFP that the State may receive for expenditures on behalf of ARKids B enrollees during the 5-year demonstration period.

   d. The following are the estimated PM/PM costs for the calculation of the budget neutrality limit.

Demonstration Year 1998	$105.76
Demonstration Year 1999	$107.45
Demonstration Year 2000	$109.17
Demonstration Year 2001	$110.92
Demonstration Year 2002	$112.69
Demonstration Year 2003	$114.49
Demonstration Year 2004	$116.32

Demonstration Year 2005 $118.18

4. The budget neutrality limit calculated in 3. above will apply to actual expenditures for Medical services, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 8-year period, the budget neutrality test will be based on the time period through the termination date.

5. If any health care related tax that was in effect during the base period, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act, CMS reserves the right to make adjustments to the budget neutrality cap.

6. CMS will enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they will submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget neutrality cap plus	8 percent
Year 2	Years 1 and 2 combined budget neutrality cap plus	3 percent
Year 3	Years 1 through 3 combined budget neutrality cap plus	1 percent
Year 4	Years 1 through 4 combined budget neutrality cap plus	0.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap plus	0 percent
Year 6	Years 1 through 6 combined budget neutrality cap plus	0 percent
Year 7	Years 1 through 7 combined budget neutrality cap plus	0 percent
Year 8	Years 1 through 8 combined budget neutrality cap plus	0 percent

ATTACHMENT E

CONTRACTORS' ACCESS STANDARDS

Contractors will provide available, accessible, comprehensive quality care to eligible beneficiaries through the use of an adequate number of institutional facilities, service locations, service sites, and professional, allied, and paramedical personnel (including dentists) for the provision of all covered services. These services must be available on an emergency basis, 24 hours a day, 7 days a week. Unless Arkansas can demonstrate that they surpass the following standards, at a minimum, the standards for making this care available will include:

1. Primary Care

a. Distance/Time: No more than 30 miles or 30 minutes for all enrollees in urban and rural service areas. In some remote areas of the State, distance and/or driving times may exceed this standard, in accordance with the usual and customary standard for the community.

b. Patient Load: The maximum patient/PCP ratio will not exceed 1000:1, including patients other than ARKids B enrollees, and will be approved by the CMS project officer 30 days prior to implementation of the program. The State, subject to CMS approval, may approve exceptions to this standard in specified situations.

c. Appointment Times: Not to exceed 30 calendar days from the date of an enrollee's request for routine and preventive care; 48 hours for non-urgent symptomatic office visits; and 24 hours for urgent symptomatic office visits.

d. Waiting Times: Beneficiaries with appointments will not routinely be made to wait longer than one hour.

2. Specialty Care

a. Distance/Time: No more than 30 miles or 30 minutes for all enrollees in urban and rural service areas. In some remote areas of the State, distance and/or driving times may exceed this standard, in accordance with the usual and customary standard for the community.

b. Appointment Times: Appointments with a specialist will be made in accordance with the timeframe appropriate to the needs of the enrollee. In general, an enrollee, or a physician on behalf of an enrollee, will be able to obtain an appointment with a specialist within 30 days of their request for routine care and 48 hours for urgent care if so desired. However, appointments for a specialist providing mental health or substance abuse services will be in accordance with the usual and customary community practice standard.

3. Emergency Care/Shock Trauma

All emergency care must be provided on an immediate basis, at the nearest equipped facility available, regardless of contract affiliation.

4. Hospitals

Transport time will be in accordance with the usual and customary community practice standard, not to exceed 30 minutes. Access time may be greater in rural areas and for mental health services, but will not exceed 60 minutes. If greater, the standard needs to be the usual and customary community practice standard for accessing care, and must be justified to the State (see 7. below).

5. Pharmacy Services

Transport time will be in accordance with the usual and customary community practice standards, not to exceed 1 hour. In rural areas, community practice standards and documentation requirements will apply (see 7. below).

6. Other

All other services not specified here will meet the usual and customary community practice standards. Such services will include, but not be limited to, laboratory and x- ray services, dental services, and durable medical equipment.

7**. Documentation**

a. All entities providing care to beneficiaries (PCPs, specialists, etc.) must have a general system in place to document adherence to the appropriate access standards (e.g., for PCPs, appointment times and waiting times). The State must utilize statistically valid sampling methods for monitoring compliance with these standards (e.g. beneficiary and provider survey).

b. In rural areas where documentation is required, the entity providing service must justfify to the State, for State approval, why they cannot meet the minimum requirement.

c. Any exceptions to any of these standards must be justified to the State, and approved by the State. The State will notify HCFA of any exceptions.

ATTACHMENT F

OPERATIONAL PROTOCOL

The State will be responsible for developing a detailed protocol describing the ARKids B Demonstration. The protocol will serve as a stand alone document that reflects the operating policies and administrative guidelines of the demonstration. The protocol will be submitted for approval no later than 30 days prior to implementation. CMS will respond within 30 days of receipt of the protocol. The State will assure and monitor compliance with the protocol. The protocol will include all requirements specified within the Special Terms and Conditions to include:

1. The organizational and structural administration that will be in place to implement, monitor, and run the demonstration, and the tasks that each will perform.

2. A complete description of Medicaid services covered under the demonstration.

3. A detailed plan for monitoring the State's coordination of care between the PCP and other entities such as public health departments, school-based clinics, etc.

4. A description of the State's beneficiary education and outreach processes, including the availability of bilingual materials/interpretation services.

5. A comprehensive description of the enrollment and disenrollment processes.

6. An overall quality assurance monitoring plan that includes a discussion of all quality indicators to be employed and methodology for measuring such indicators; surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys; credentialing requirements and monitoring; fraud control provisions and monitoring; and the proposed provider-enrollee ratios, access standards, etc.

7. Description of how claims data file would be made available to an evaluator.

8. The complaint and appeal policies that will be in place at the State level.

9. Basic features of the administrative and management data system.

10. Description of procedures related to the State’s financial reporting process (see Attachment A - General Financial Requirements, items A.2.e. and A.3.a.).

11. Description of all referral authorization plans, and policies and procedures relating to them.